Filing at a Glance

Company:	Liberty Bankers Life Insurance Company
Product Name:	LBL - Supp Health
State:	District of Columbia
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	12/10/2019
SERFF Tr Num:	CSGA-132184114
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	IMO APP/REPLACEMENT NOTICE
Implementation Date Requested:	On Approval
Author(s):	Tammy Conn, Brad English
Reviewer(s):	Colin Johnson (primary)
Disposition Date:	
Disposition Status:	
Implementation Date:	

State: District of Columbia **Filing Company:** Liberty Bankers Life Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: LBL - Supp Health
Project Name/Number: IMO Application/IMO Application

General Information

Project Name: IMO Application
Project Number: IMO Application
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Tammy Conn

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 12/11/2019
State Status Changed:
Created By: Tammy Conn
Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null
Include Exchange Intentions: No

Filing Description:
Please see Cover Letter on Supporting Documentation tab.

Company and Contact

Filing Contact Information

Tammy Conn, Compliance Analyst
11011 Q St
#101b
Omaha, NE 68137

tconn@csgactuarial.com
402-502-7747 [Phone] 1008 [Ext]

Filing Company Information

(This filing was made by a third party - csgactuarial)

Liberty Bankers Life Insurance Company
1605 LBJ Freeway
Suite 710
Dallas, TX 75234
(469) 522-4200 ext. [Phone]

CoCode: 68543
Group Code:
Group Name:
FEIN Number: 25-1093227

State of Domicile: Oklahoma
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*CSGA-132184114*	***State Tracking #:***		***Company Tracking #:***	*IMO APP/REPLACEMENT NOTICE*

State:	*District of Columbia*	***Filing Company:***	*Liberty Bankers Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*LBL - Supp Health*		
Project Name/Number:	*IMO Application/IMO Application*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Supplemental Health Application	LBL-SH IMO-APP-19 DC	AEF	Initial			LBL-SH-IMO-APP-19 DC.pdf
2		Replacement Notice	LBL-CI-RN-18	OTH	Initial			LBL-CI-RN-18.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NAP**	Network Access Plan
NOC	Notice of Coverage	**OTH**	Other
OUT	Outline of Coverage	**PJK**	Policy Jacket
POL	Policy/Contract/Fraternal Certificate	**POLA**	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider
PRC	Provider Contract/Provider Addendum/Provider Leading Agreement	**PRD**	Provider Directory

Liberty Bankers Life Insurance Company

Liberty Bankers Life Insurance Company
Home Office: [1605 LBJ Freeway, Suite 700, Dallas, Texas, 75234]
Administrative Office: [PO Box 224, Brownwood, TX 76804-0224]

Application for
ACCIDENT and/or
CANCER LUMP SUM and/or
HEART ATTACK OR STROKE LUMP SUM
INSURANCE POLICIES

Section 1. Coverage Options (to be completed by Producer)

Writing Agent Name: _____ Writing Agent #: _____

☐ New Coverage ☐ Reinstatement* ☐ Change in Benefit Coverage*

*Existing Policyowner's Name: _____ *Existing Policy Number _____

[☐ Add Rider(s) to existing policy] [☐ Add Dependent(s) to existing policy]

Requested Effective Date: _____

Section 2. Proposed Insured(s)/Insured Applying for Coverage

NAME (First-Middle-Last)	GENDER	DATE OF BIRTH (MM/DD/YY)	SOCIAL SECURITY NUMBER	CURRENT OCCUPATION	ARE YOU DISABLED?
PROPOSED INSURED/INSURED		/ /	/ /		☐ Yes
SPOUSE		/ /	/ /		☐ Yes
CHILD #1		/ /	/ /		☐ Yes
CHILD #2		/ /	/ /		☐ Yes
CHILD #3		/ /	/ /		☐ Yes
CHILD #4		/ /	/ /		☐ Yes

Section 3. Proposed Insured/Insured's Information (Policyowner)

HOME ADDRESS (required): STREET			MAILING ADDRESS (if different from home address): STREET or PO BOX		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
EMAIL ADDRESS					
CELL PHONE ( )	HOME PHONE ( )		WORK PHONE ( )		

Section 4. Beneficiary Information

Benefits unpaid at death are payable to your beneficiary.
Please provide beneficiary information for Proposed Insured/Insured (and Spouse if applicable).
The Proposed Insured/Insured will be the beneficiary for any child(ren) named in the application.

PROPOSED INSURED(s)	NAME OF BENEFICIARY	DATE OF BIRTH (MM/DD/YY)	RELATIONSHIP TO PROPOSED INSURED/INSURED	PRIMARY OR CONTINGENT	PERCENTAGE OF BENEFIT
		/ /			
		/ /			
		/ /			
		/ /			

Section 5. Premium Payment Method

SELECT ONE OF THE FOLLOWING

☐ ELECTRONIC BANK DRAFT Premium Mode: ☐ MONTHLY ☐ QUARTERLY ☐ SEMI-ANNUALLY ☐ ANNUALLY

☐ DIRECT BILL Premium Mode: (monthly not available) ☐ QUARTERLY ☐ SEMI-ANNUALLY ☐ ANNUALLY

Section 6a. Cancer, Heart or Stroke Benefit Selection

COVERAGE TYPE: ☐ INDIVIDUAL ☐ FAMILY

POLICY SELECTION: ☐ LUMP SUM CANCER COVERAGE and/or ☐ LUMP SUM HEART OR STROKE COVERAGE

Lump Sum Benefit $_____

Units ($5,000 per unit) _____

OPTIONAL RIDER SELECTION: ☐ RETURN OF PREMIUM

Total Policy [and Rider(s)] Mode Premium $_____

Section 6b. Accident Benefit Selection

COVERAGE TYPE: ☐ INDIVIDUAL ☐ FAMILY

POLICY SELECTION: ☐ ACCIDENT BENEFIT POLICY

Coverage Level (A, B, C or D) _____

Level A = 3 units, Level B = 2 units, Level C = 1 unit, Level D = ½ unit

OPTIONAL RIDER SELECTION: ☐ RETURN OF PREMIUM ☐ RECOVERY INCOME BENEFIT RIDER Weekly Recovery Benefit $_____ Units ($200/wk. per unit) _____

Total Policy [and Rider(s)] Mode Premium $_____

Section 7. Health Questions

COMPLETE THE FOLLOWING: PARTS A & B *if applying for* LUMP SUM CANCER POLICY
PARTS A & C *if applying for* LUMP SUM HEART OR STROKE POLICY
Any "Yes" answer will exclude a Proposed Insured named from coverage.

PART A	Has any Proposed Insured ever been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS related Complex (ARC) or HIV Infection? **If "Yes", please provide name of each Proposed Insured:**	☐ YES	☐ NO
	Within the past 2 years, has any Proposed Insured been advised by a member of the medical profession to have any diagnostic test, is awaiting any results from a diagnostic test, or has had any abnormal diagnostic test results, or has had a medical condition, symptom or abnormality that would have caused an ordinarily prudent person to seek medical treatment or advice, but has not yet done so? **If "Yes", please provide name of each Proposed Insured:**	☐ YES	☐ NO
PART B	In the past 5 years, has any Proposed Insured been diagnosed as having, received medication for, or been treated by a medical practitioner for Leukemia, Hodgkin's Disease, lymphoma, malignant melanoma, sarcoma, Carcinoma in Situ, tumor or growth, or any internal cancer, or had radiation or chemotherapy for any of these conditions? **If "Yes", please provide name of each Proposed Insured:**	☐ YES	☐ NO
PART C	In the past 10 years, has any Proposed Insured been diagnosed as having, received medication for, or been treated by a medical practitioner for heart attack, heart bypass, angioplasty or stent placement, angina, stroke, or Transient Ischemic Attack (TIA)? **If "Yes", please provide name of each Proposed Insured:**	☐ YES	☐ NO

Section 8. Other Insurance

Will any existing inforce health insurance be replaced or changed if this policy is issued? If "Yes", please complete a Replacement Form.	☐ YES	☐ NO

COMPANY NAME_____ POLICY NUMBER_____

Section 9. Bank Draft Authorization Form

IMPORTANT: When choosing to pay initial premium by Electronic Bank Draft
THE FIRST PREMIUM WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY WHEN YOUR POLICY IS ISSUED.

The first withdrawal date may be different from the monthly date selected for renewal premiums. Subsequent premiums will be withdrawn approximately thirty (30) days from the effective date of coverage or on the date specified on this application.

I authorize Liberty Bankers Life Insurance Company to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes. I authorize you, my financial institution, to pay from my account to "Liberty Bankers Life Insurance Company" any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

I would like my automatic monthly withdrawal to come from my (check one below) on the_____ day (must be between the 1st and 28th) of the month:

☐ CHECKING: **Write routing and account numbers below and circle the corresponding numbers OR attach a voided check.**

☐ SAVINGS: **Write routing and account numbers below and circle the corresponding numbers.**
Please ask your financial institution to verify that this EFT (Electronic Funds Transfer) will be accepted.

BANK ROUTING NUMBER:

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

FOR CHECKING ACCOUNTS:

TAPE OR STAPLE VOIDED CHECK HERE

(OPTIONAL)

ACCOUNT NUMBER:

0	0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9	9

BANK NAME:_____ PHONE #:_____

BANK ADDRESS:

PAYOR NAME: _____

PAYOR SIGNATURE: (Must match your financial institution's records).
A copy of this document sent via electronic transmission is as valid as the original.

X_____ DATE_____

Section 10. Authorization and Acknowledgement by All Proposed Insureds Over Age of Majority

I hereby authorize any medical practitioner, physician, hospital, clinic, pharmacy benefit manager, or other medical related facility, insurance company, insurance support organization, business partner, pharmacy, government agency, group policy holder, employer, benefit plan administrator, the Department of Motor Vehicle Registration, and paramedical facility to provide to Liberty Bankers Life Insurance Company (LBL) or its reinsurers information concerning advice, care, or treatment sought by or provided to me and/or any other applicant for coverage, including information relating to medical history, medical conditions, treatment, hospitalizations or confinements, ailments, pharmacy prescription drugs, and/or drug, alcohol or tobacco usage of the applicant(s). I also authorize all said sources to give such records or knowledge to any agent, attorney, consumer reporting agency or independent administrator, including medical record retrieval services or pharmaceutical services, acting on behalf of LBL. It is understood that LBL's underwriters, claim examiners, reinsurers, attorneys, or the medical director may disclose such health information to the aforementioned parties for purposes of underwriting, compliance, record clarification or explanation, or in response to litigation, summons, or subpoenas. I understand that after this information is disclosed, the recipient may re-disclose it resulting in loss of protection by federal regulations. I authorize MIB, Inc. to provide any medical or personal information that it has about me to LBL or any MIB-authorized third-party administrator performing underwriting services on LBL's behalf. I also authorize LBL, its reinsurer or authorized third-party administrator, to make a brief report of my protected health information to the MIB, Inc.

I understand that:

- such information will be used by LBL for underwriting and insurability determinations;
- I may refuse to sign this authorization and that my refusal to sign will affect my ability to obtain insurance coverage;
- a picture copy or photocopy of this authorization shall be as valid as the original; and
- any authorized representative of the proposed insured is entitled to receive a copy of this authorization upon request.

This authorization is valid from the date signed for a duration of 24 months. I understand I may revoke the authorization at any time, except to the extent that action has been taken in reliance on this authorization, by sending written notice to the Underwriting Department of Liberty Bankers Life Insurance Company, [PO Box 224, Brownwood, TX 76804-0224]. I may inspect or copy any information used or disclosed under this authorization, if signed.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

To the best of my knowledge and belief, I represent that my answers and statements on this application are true and complete. I understand that my policy benefits can start no earlier than my effective date, and only after my first month's premium has been received and/or processed and my application has been approved by Liberty Bankers Life Insurance Company.

Dated at _____ on ___/___/___ X _____
City State Date Proposed Insured/Insured's Signature

Dated at _____ on ___/___/___ X _____
City State Date Proposed Insured/Insured's **Spouse** Signature

Section 11. Agent's Statement

Premium payment information must accompany application.

I certify that during an interview with the Proposed Insured, I have truly and accurately recorded in the application the information supplied by the Proposed Insured.

X _____ _____ _____ ___/___/___
Signature of Licensed Producer | Producer # | Split % | Date

Split application with:

_____ _____ _____
Producer Name | Producer # | Split %

_____ _____ _____
Producer Name | Producer # | Split %

(must equal 100%)

Liberty Bankers Life Insurance Company
Home Office: [1605 LBJ Freeway, Suite 700, Dallas, Texas, 75234]
Administrative Office: [PO Box 224, Brownwood, TX 76804-0224]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to Your application, You intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Liberty Bankers Life Insurance Company. For Your own information and protection, You should be aware of and seriously consider certain factors that may affect the insurance protection available to You under the new policy.

(1) Health conditions which You may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under Your present policy.

(2) You may wish to secure the advice of Your present insurer or its agents regarding the proposed replacement of Your present policy. This is not only Your right, but it is also in Your best interests to make sure You understand all the relevant factors involved in replacing Your present coverage.

(3) If, after due consideration, You still wish to terminate Your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning Your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund Your premium as though Your policy had never been in force. After the application has been completed and before You sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date	Agent Name (Print)
Applicant's Signature	Agent's Signature

Liberty Bankers Life Insurance Company
Home Office: [1605 LBJ Freeway, Suite 700, Dallas, Texas, 75234]
Administrative Office: [PO Box 224, Brownwood, TX 76804-0224]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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(1) Health conditions which You may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under Your present policy.

(2) You may wish to secure the advice of Your present insurer or its agents regarding the proposed replacement of Your present policy. This is not only Your right, but it is also in Your best interests to make sure You understand all the relevant factors involved in replacing Your present coverage.

(3) If, after due consideration, You still wish to terminate Your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning Your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund Your premium as though Your policy had never been in force. After the application has been completed and before You sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____	_____
Date	Agent Name (Print)
_____	_____
Applicant's Signature	Agent's Signature

SERFF Tracking #:	*CSGA-132184114*	***State Tracking #:***		***Company Tracking #:***	*IMO APP/REPLACEMENT NOTICE*

State:	*District of Columbia*	***Filing Company:***	*Liberty Bankers Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*LBL - Supp Health*		
Project Name/Number:	*IMO Application/IMO Application*		

Supporting Document Schedules

Satisfied - Item:	Cover Letter
Comments:	
Attachment(s):	DC - Cover.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	CO - SoV.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Authorization to File
Comments:	
Attachment(s):	SERFF Authorization - CSG - 2019.pdf
Item Status:	
Status Date:	

December 10, 2019

RE: Liberty Bankers Life Insurance Company Submission (NAIC# 68543 / FEIN# 25-1093227)
Individual Supplemental Insurance

Enclosed Material:

Form Number	Form Description
LBL-SH-IMO-APP-19 DC	Application for Accident, Cancer Lump Sum, and Heart Attack/Stroke
LBL-CI-RN-18	Notice to Applicant Regarding Replacement

CSG Actuarial, LLC is filing the above forms for your review and approval on behalf of Liberty Bankers Life Insurance Company. A letter of authorization is attached to the Supporting Document tab for reference.

These forms are new and do not replace any previously filed forms. They will be used with the following approved forms:

Form Number	Form Description	SERFF Approval
LBL-CI-A-18 DC	Accident Benefit Policy	CSGA-131562376 on 3/12/19
LBL-CI-A-OOC-18 DC	Accident Benefit Outline of Coverage	
LBL-CI-ARIBR-18	Recovery Income Indemnity Benefit Rider	
LBL-CI-RPDAR-18	ROP Upon Death With Acceleration Indemnity Benefit Rider	
LBL-CI-RPDR-18	ROP Upon Death Indemnity Benefit Rider	
LBL-CI-CP-18 DC	Cancer Policy	CSGA-131562442 on 12/10/18
LBL-CI-CP-OOC-18 DC	Cancer Outline of Coverage	
LBL-CI-CHSR-18	Heart Attack or Stroke Benefit Rider	
LBL-CI-HSP-18 DC	Heart Attack or Stroke Policy	CSGA-131562477 on 1/3/19
LBL-CI-HSP-OOC-18 DC	Heart Attack or Stroke Outline of Coverage	

Please note: LBL-CI-RN-18 will also be used with the following application:

Form Number	Form Description	SERFF Approval
LBL-CI-APP-18 DC	Application for Accident, Cancer Lump Sum and Heart Attack/Stroke	CSGA-131562376 on 3/12/19

Any variable information within the forms is shown in brackets and explained in the attached Statement of Variability.

Please note that minor modifications in paper size and stock, ink, border, Company logo, signatures and formatting to accommodate system needs or internet format can occur. We reserve the right to correct at any time any typographical errors that do not impact benefits or intent of language.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your state.

CSG Actuarial, LLC appreciates the Department's time and consideration in the review of this filing. If I may be of additional assistance as you complete your review, please do not hesitate to contact me at 402-502-7747 ext. 1008 or via email tconn@csgactuarial.com.

Sincerely,
Tammy Conn, Compliance Manager
CSG Actuarial, LLC

Liberty Bankers Life Insurance Company

STATEMENT OF VARIABILITY

The following information has been bracketed as variable in the event of changes.

Application: LBL-SH-IMO-APP-19 CO

- Logo – in the event of rebranding

- Home Office Address
- Administrative Office Address

Home Office: [1605 LBJ Freeway, Suite 700, Dallas, Texas, 75234]
Administrative Office: [PO Box 224, Brownwood, TX 76804-0224]

- Application Options — Will be displayed or excluded.

[☐ Add Rider(s) to existing policy] [☐ Add Dependent(s) to existing policy]

[OPTIONAL RIDER SELECTION: ☐ RETURN OF PREMIUM]	[OPTIONAL RIDER SELECTION: ☐ RETURN OF PREMIUM ☐ RECOVERY INCOME BENEFIT RIDER Weekly Recovery Benefit $_____ Units ($200/wk. per unit) _____]
Total Policy [and Rider(s)] Mode Premium $_____	**Total Policy [and Rider(s)] Mode Premium $**_____

- Underwriting Department Address — Underwriting Department of Liberty Bankers Life Insurance Company, [PO Box 224, Brownwood, TX 76804-0224]

Notice to Applicant Regarding Replacement: LBL-CI-RN-18

- Logo – in the event of rebranding

- Home Office Address
- Administrative Office Address

Home Office: [1605 LBJ Freeway, Suite 700, Dallas, Texas, 75234]
Administrative Office: [PO Box 224, Brownwood, TX 76804-0224]

Liberty Bankers Life
Insurance Company

February 1, 2019

To Whom It May Concern:

This letter authorizes CSG Actuarial, LLC. to submit form and rate filings for approval on behalf of Liberty Bankers Life Insurance Company.

CSG Actuarial, LLC. may correspond with the State Departments of Insurance regarding any questions they may have concerning the filings.

This authorization is to be effective until revoked in writing by an authorized representative of Liberty Bankers Life Insurance Company.

Sincerely,

Eric Johansson
Chief Operations Officer

1605 LBJ Freeway Suite 710 Dallas, Texas 75234 469.522.4200 Fax 469.522.4401
www.libertybankerslife.com